Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH LLC
5445 LA SIERRA DRIVE 204
DALLAS TX 75231

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 20

MFDR Tracking Number
M4-10-2900-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated September 9, 2009: "The patient was referred for the Chronic Pain Management Program. The services were provided and the claim was paid incorrectly. CPT code 9799 CPCA was billed at 7.5 units but only 7 units were paid. Please refer to the attached HCFA for further reference. "

Requestor's Position Summary noted on the Table of Disputed Services: "7.75 units were billed but only 7 units were paid."

Amount in Dispute: $65.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29, 2009	Chronic Pain Management Program – CPT Code 97799-CPCA (7.75 hours per day / 7 hrs. were paid)	$65.62	$65.62

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, Medical Fee Guideline for Workers' Compensation Specific Services.

March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 13, 2009
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - P303-This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.
   - W1-Workers compensation state fee schedule adjustment.
   - Z547-This bill was reviewed in accordance with your Fee for Service contract with First Health.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Does a contract exist in this dispute?
2. What is the disputed date of service?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the disputed services based upon reason codes "45-Charges exceed your contracted/legislated fee arrangement"; "P303-This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business" and "Z547-This bill was reviewed in accordance with your Fee for Service contract with First Health".

   According to the explanation of benefits, the services in dispute were paid using a contracted fee arrangement. Texas labor Code §413.011(d-3) states that the division may request copies of each contract under which fee s are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On August 26, 2010, the division requested a copy of the contract between the network and the health care provider. The carrier failed to provide a copy of the requested documentation. For that reason, the disputed health care will be reviewed in accordance with applicable division rules and fee guidelines.

2. 28 Texas Administrative Code §133.307(c)(2)(C), requires that the request shall include "the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division." Review of the submitted documentation finds that the requestor has not completed the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division. Specifically, the requestor listed that the disputed date of service is "04/29/2009" on the Table of Disputed Services, and on the heading listed date of service "07/28/09". Because the requestor listed the date of service on the heading and other relevant correspondence, the Division determines that the date of service is July 28, 2009.

3. Based upon the Table of Disputed Services, the submitted bill, and medical records, the claimant attended 7.75 hours of chronic pain management services on the disputed date of service. 28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

   > (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
   >
   > (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The Division finds that the requestor billed CPT code 97799-CP-CA for 7.75 hours on the disputed date of service.. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour x 7.75 hours = $968.75. The carrier paid $871.88. Therefore, the difference between the MAR and amount paid is $96.87. The requestor is seeking dispute resolution for $65.62; this amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $65.62.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $65.62 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	4/25/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.